

GRAND STRAND HEALTH SYSTEM – PRIMARY CARE
Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Referring Provider/How did you hear about us? _____

E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F – Female M - Male Transgender

Race American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other _____

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number _____ - _____ - _____ Employer Name _____

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? Yes No

Emergency Contact Relationship to Patient _____ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party Another Patient Guarantor Self **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/DD ____/YYYY _____

Social Security Number _____ - _____ - _____ Telephone _____

E-Mail Address _____ Sex F – Female M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____